Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TWELVE OAKS MEDICAL CENTER
c/o HOLLAWAY & GUMBERT
3701 KIRBY DRIVE, SUITE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
#54

MFDR Date Received
SEPTEMBER 14, 2005

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-06-0550-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "…Per DWC Rule 134.401(c)(6), claim pays at 75% of total charges as charges exceed $40,000.00 stop-loss threshold..."

Requestor's Supplemental Position Summary Dated October 10, 2005: "…To date, a total of $3,455.68 has been paid in connection with this claim. It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines of the Division... The services provided to [injured worker] were for treatment of severe pain resulting from 'post traumatic internal disk derangement with herniation C4-6.' As a result of his condition, [injured worker] underwent several operations summarized on the operative report as 1) anterior cervical diskectomy decompression of the spinal cord nerve root C4-5; 2) anterior cervical diskectomy and decompression of the spinal cord nerve root C5-6; 3) anterior cervical interbody arthrodesis C4-5; 4) anterior cervical interbody arthrodesis C5-6; 5) anterior cervical instrumentation C4-6 with DePuy titanium plate and screws; and 6) harvesting of right anterior iliac crest structural autograft x2. The anesthesia records note [injured worker] was under anesthesia for the operations for a period of at least 3 hours. Postoperatively, the records note [injured worker] developed fever to 101.2, along with abnormal blood, chemistry values indicating possible infection, and for which he was prescribed antibiotics. The records also note that [injured worker] complained of headaches, left neck and arm, back, and chest pain for which additional medical services were required…Under Rule 134.401(c)(6) of the acute care inpatient hospital fee guidelines of the Division, this claim would be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss threshold of $40,000.00 resulting in a reimbursement of $35,470.27."

Amount in Dispute: $32,014.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 28, 2005: "This dispute involves the carrier's payment for date of service 9/14/2004 to 9/20/2004 for which the requestor charges $47,293.69; for services that were NOT unusually extensive or costly. Texas Mutual paid $3,455.68 for a three day inpatient surgical hospital stay. The requestor believes it is entitled to an additional $32,014.59. This requestor has not provided information to support that the services were unusually costly or extensive. "

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 14 through 20, 2004	Inpatient Hospital Services	$32,014.59	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- F – fee guideline MAR reduction
- TR – Reimbursed in accordance with the Texas Hospital Fee Guideline. Services do not appear unusually costly.
- JL – Length of stay exceeds number of days previously precertified/preauthorized. Documentation does not support medical necessity for additional days.
- A – preauthorization required but not requested
- YF – Reduced or denied in accordance with the appropriate fee guideline ground rule and/or maximum allowable reimbursement.
- 891 – The insurance company is reducing or denying payment after reconsidering a bill.
- Billed charges do not meet the stop-loss method standard of the 08/01/97 acute care inpatient hospital fee guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay.
- Pre-authorization was given for 3 days only. There is no documentation on…

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as

described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the division concludes that the total audited charges exceed $40,000.

2. The requestor in its original position statement asserts that "The services provided to [injured worker] were for treatment of severe pain resulting from 'post traumatic internal disk derangement with herniation…Under Rule 134.401(c)(6) of the acute care inpatient hospital fee guidelines of the TWCC, this claim would be reimbursed at the stop-loss rate of 75% as the total audited charges exceed the minimum stop-loss threshold of $40,000.00 resulting in a reimbursement of $35,470.27." The requestor asserts that it is entitled to the stop loss method of payment. As noted above, the Third Court of Appeals in its November 13, 2008 opinion concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services compared to similar services or admissions; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

4. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was six days; however, documentation supports that the Carrier pre-authorized a length of stay of three days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $3354.00 for the three authorized days.

   - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)." A review of the submitted hospital bill finds that the requestor billed $4006.25 for revenue code 610-Sp cerv w/wo CM. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 610 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

The division concludes that the total allowable for this admission is $3354.00. The respondent issued a total payment of $3455.68. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.